

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6923

## CERTIFICATE OF DEATH

Reg. Dist. No.

06917

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Reisterstown General Hosp.</u>			d. STREET ADDRESS <u>416 W. Cannon</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Milton</u> Last <u>Barwick</u>			4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 24, 1907</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Edward Barwick</u>			14. MOTHER'S M maiden name <u>Marietta Meredith</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>220-07-2172</u>		17. INFORMANT <u>Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
		20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>58</u> , to <u>June 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>58</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>A.C. Dick</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>		DATE SIGNED <u>6-26-58</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 27</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>	
				22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06918

6924

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown 37</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Anne's Hospital</b>				d. STREET ADDRESS <b>308 S. Front Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Addie</b> Middle <b>Camille</b> Last <b>Camille</b>				4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1885</b>		9. AGE (In years last birthday) yrs. <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook and domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Nicholas Camille</b>				14. MOTHER'S MAIDEN NAME <b>Wilmina Boyer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>217-3e-8396</b>		17. INFORMANT Address <b>Catherine Bridges, Phila. Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary artery disease</b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-16</b> , 19 <b>58</b> , to <b>6-18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-18</b> , 19 <b>58</b> , and that death occurred at <b>9:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>A.C. Dick</b> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>A.C. Dick</b>				City or town, state <b>Chestertown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Golts Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Golts Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Darby, Earton, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 26 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6925

## CERTIFICATE OF DEATH

Reg. Dist. No.

06919

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Still Pond</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Anne's</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Allie</u> Middle <u>A.</u> Last <u>JOHNSON</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 5, 1898</u>	
9. AGE (In years lost birthday) <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Hosp. Records</u> Address <u>Chestertown Kent</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>C-V.R. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. <u>11</u> p. m. <u>19</u> Month, Day, Year			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 28</u> , 19 <u>58</u> , to <u>June 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>58</u> , and that death occurred at <u>11:15</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.C. Dick</u>				ADDRESS (Street, city or town, state) <u>Chestertown Md</u> DATE SIGNED <u>6-30-58</u>			
PHYSICIAN'S NAME (Type) <u>A. C. Dick</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMT</u>		22d. LOCATION (City, town, or county) (State) <u>STILL POND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>STILL POND, MD</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>—</u>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06920

1. PLACE OF DEATH a. COUNTY <b>Kent County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Golts</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Golts</b>	
3. NAME OF DECEASED (Type or print) <b>Linda Leoma Lucas</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1954</b>
9. AGE (In years last birthday) <b>3</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) <b>Chestertown, Md.</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. FATHER'S NAME <b>Harold Lucas</b>		15. MOTHER'S MAIDEN NAME <b>Susie Frances Johns</b>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Birth Reg. Notice</b>		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>929.0</b> DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell into well.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>June 28 19 58</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Golts</b> (County) <b>Kent</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Arthur T. Keefe, Jr.</b>		DATE SIGNED <b>6/30/58</b>	
EXAMINER'S NAME (Type) <b>Arthur T. Keefe, Jr., M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/1/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GOLT CEM.</b>		22d. LOCATION (City, town, or county) <b>GOLT, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		24a. REC'D BY REGISTRAR <b>JUL 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur T. Keefe</b>			

FOR STATE  
HEALTH DEPT.

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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6926

## CERTIFICATE OF DEATH

Reg. Dist. No.

06921

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chestertown(rural)</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Annes General</b>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard Earl Perry</b>			4. DATE OF DEATH Month Day Year <b>June 8 19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1886 (exactly 72 yrs.)</b>		9. AGE (In years last birthday) <b>72 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James Perry</b>			14. MOTHER'S MAIDEN NAME <b>Ella Clark</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-12-5856</b>	17. INFORMANT Address <b>Hospital records, Chestertown, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> several years DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Pulmonary Emphysema (10 years)</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 7</b> , 19 <b>58</b> , to <b>June 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 8</b> , 19 <b>58</b> , and that death occurred at <b>6:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>June 8, 58</b>					
ACTUAL SIGNATURE <b>Robert W. Farr</b> M.D.					
PHYSICIAN'S NAME (Type) <b>Robert W. Farr, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>JUN 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Search</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06922

6927

## CERTIFICATE OF DEATH

Items 11, 12 Film 230 6-9-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown,</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>208 Court St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Geneva</b> Middle <b>Richardson</b> Last <b>Richardson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1910</b>
9. AGE (In years last birthday) yrs. <b>47</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>7</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. Chester</b>		14. MOTHER'S MAIDEN NAME <b>Katie Chester</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>yes</b>	
17. INFORMANT <b>Thomas Richardson</b> Address <b>208 Court St. Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO <b>421.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aortic insufficiency &amp; Aortitis</b> DUE TO (c) <b>30 months known for 30 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 months known for 30 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/31</b> , 19 <b>55</b> , to <b>6/1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/1</b> , 19 <b>58</b> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>June 2, 1958</b>			
ACTUAL SIGNATURE <b>Robert W. Farr</b> PHYSICIAN'S NAME (Type) <b>Chestertown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 5, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Janes Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>near Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Walley</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 4 '58</b>	
ADDRESS <b>Chestertown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Al L. Leach</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE, 18

6928

## CERTIFICATE OF DEATH

06923

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>3 da.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John F. Stokes</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 11 1889</b>
9. AGE (In years lost birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cashier</b>	
11. BIRTHPLACE (State or foreign country) <b>Worton Kent Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. O. Stokes</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Friel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-03-3925</b>	
17. INFORMANT <b>Margaret Metcalfe Stokes</b>		Address <b>Sudlersville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Hypertensive Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/21</b> , 19 <b>58</b> , to <b>6/23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/23</b> , 19 <b>58</b> , and that death occurred at <b>8:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas J. Solon</b>		ADDRESS (Street, city or town, state) <b>Chesapeake</b>	
PHYSICIAN'S NAME (Type) <b>THOMAS J. SOLON</b>		DATE SIGNED <b>6/23/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 26/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Sudlersville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

CERTIFICATE OF DEATH

Page One of Two

<p>1. NAME OF DECEASED                  JAMES EARL RAY</p>		<p>2. SEX                  Male</p>		<p>3. RACE                  White</p>	
<p>4. DATE OF BIRTH                  May 19, 1928</p>		<p>5. PLACE OF BIRTH                  Jackson, Tennessee</p>		<p>6. DATE OF DEATH                  May 14, 1968</p>	
<p>7. TIME OF DEATH                  11:00 AM</p>		<p>8. PLACE OF DEATH                  Federal Penitentiary, Nashville, Tennessee</p>		<p>9. CAUSE OF DEATH                  Heart Disease</p>	
<p>10. MANNER OF DEATH                  Natural</p>		<p>11. SIGNATURE OF PHYSICIAN                  [Signature]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Signature]</p>	
<p>13. NAME OF HOSPITAL                  Federal Penitentiary</p>		<p>14. NAME OF CITY                  Nashville</p>		<p>15. NAME OF STATE                  Tennessee</p>	
<p>16. NAME OF COUNTY                  Davidson</p>		<p>17. NAME OF DISTRICT                  Nashville</p>		<p>18. NAME OF WARD                  A-1</p>	
<p>19. NAME OF ROOM                  101</p>		<p>20. NAME OF BUILDING                  Administration Building</p>		<p>21. NAME OF CAMPUS                  Nashville</p>	
<p>22. NAME OF STREET                  Nashville</p>		<p>23. NAME OF CITY                  Nashville</p>		<p>24. NAME OF STATE                  Tennessee</p>	
<p>25. NAME OF COUNTY                  Davidson</p>		<p>26. NAME OF DISTRICT                  Nashville</p>		<p>27. NAME OF WARD                  A-1</p>	
<p>28. NAME OF ROOM                  101</p>		<p>29. NAME OF BUILDING                  Administration Building</p>		<p>30. NAME OF CAMPUS                  Nashville</p>	
<p>31. NAME OF STREET                  Nashville</p>		<p>32. NAME OF CITY                  Nashville</p>		<p>33. NAME OF STATE                  Tennessee</p>	
<p>34. NAME OF COUNTY                  Davidson</p>		<p>35. NAME OF DISTRICT                  Nashville</p>		<p>36. NAME OF WARD                  A-1</p>	
<p>37. NAME OF ROOM                  101</p>		<p>38. NAME OF BUILDING                  Administration Building</p>		<p>39. NAME OF CAMPUS                  Nashville</p>	
<p>40. NAME OF STREET                  Nashville</p>		<p>41. NAME OF CITY                  Nashville</p>		<p>42. NAME OF STATE                  Tennessee</p>	
<p>43. NAME OF COUNTY                  Davidson</p>		<p>44. NAME OF DISTRICT                  Nashville</p>		<p>45. NAME OF WARD                  A-1</p>	
<p>46. NAME OF ROOM                  101</p>		<p>47. NAME OF BUILDING                  Administration Building</p>		<p>48. NAME OF CAMPUS                  Nashville</p>	
<p>49. NAME OF STREET                  Nashville</p>		<p>50. NAME OF CITY                  Nashville</p>		<p>51. NAME OF STATE                  Tennessee</p>	
<p>52. NAME OF COUNTY                  Davidson</p>		<p>53. NAME OF DISTRICT                  Nashville</p>		<p>54. NAME OF WARD                  A-1</p>	
<p>55. NAME OF ROOM                  101</p>		<p>56. NAME OF BUILDING                  Administration Building</p>		<p>57. NAME OF CAMPUS                  Nashville</p>	
<p>58. NAME OF STREET                  Nashville</p>		<p>59. NAME OF CITY                  Nashville</p>		<p>60. NAME OF STATE                  Tennessee</p>	
<p>61. NAME OF COUNTY                  Davidson</p>		<p>62. NAME OF DISTRICT                  Nashville</p>		<p>63. NAME OF WARD                  A-1</p>	
<p>64. NAME OF ROOM                  101</p>		<p>65. NAME OF BUILDING                  Administration Building</p>		<p>66. NAME OF CAMPUS                  Nashville</p>	
<p>67. NAME OF STREET                  Nashville</p>		<p>68. NAME OF CITY                  Nashville</p>		<p>69. NAME OF STATE                  Tennessee</p>	
<p>70. NAME OF COUNTY                  Davidson</p>		<p>71. NAME OF DISTRICT                  Nashville</p>		<p>72. NAME OF WARD                  A-1</p>	
<p>73. NAME OF ROOM                  101</p>		<p>74. NAME OF BUILDING                  Administration Building</p>		<p>75. NAME OF CAMPUS                  Nashville</p>	
<p>76. NAME OF STREET                  Nashville</p>		<p>77. NAME OF CITY                  Nashville</p>		<p>78. NAME OF STATE                  Tennessee</p>	
<p>79. NAME OF COUNTY                  Davidson</p>		<p>80. NAME OF DISTRICT                  Nashville</p>		<p>81. NAME OF WARD                  A-1</p>	
<p>82. NAME OF ROOM                  101</p>		<p>83. NAME OF BUILDING                  Administration Building</p>		<p>84. NAME OF CAMPUS                  Nashville</p>	
<p>85. NAME OF STREET                  Nashville</p>		<p>86. NAME OF CITY                  Nashville</p>		<p>87. NAME OF STATE                  Tennessee</p>	
<p>88. NAME OF COUNTY                  Davidson</p>		<p>89. NAME OF DISTRICT                  Nashville</p>		<p>90. NAME OF WARD                  A-1</p>	
<p>91. NAME OF ROOM                  101</p>		<p>92. NAME OF BUILDING                  Administration Building</p>		<p>93. NAME OF CAMPUS                  Nashville</p>	
<p>94. NAME OF STREET                  Nashville</p>		<p>95. NAME OF CITY                  Nashville</p>		<p>96. NAME OF STATE                  Tennessee</p>	
<p>97. NAME OF COUNTY                  Davidson</p>		<p>98. NAME OF DISTRICT                  Nashville</p>		<p>99. NAME OF WARD                  A-1</p>	
<p>100. NAME OF ROOM                  101</p>		<p>101. NAME OF BUILDING                  Administration Building</p>		<p>102. NAME OF CAMPUS                  Nashville</p>	



may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6934

CERTIFICATE OF DEATH

Reg. Dist. No.

06924

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Still Pond</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				d. STREET ADDRESS -----			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>Toulson</b> Last <b>Toulson</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1890</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.		IF UNDER 24 HRS. Hours <b>14</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Henry Toulson</b>				14. MOTHER'S MAIDEN NAME <b>Susan Emma Wilmer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-20-0001</b>		17. INFORMANT Address <b>Mrs. Mary Clark Still Pond, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of lung</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of breast</b> DUE TO (c) <b>6 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac decompensation</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 13, 1958</b> , to <b>June 14, 1958</b> , that I last saw the deceased alive on <b>June 13, 1958</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Florence Deringer Joyce</b> M.D.				ADDRESS (Street, city or town, state) <b>Worton Md</b> DATE SIGNED <b>6/14/58</b>			
PHYSICIAN'S NAME (Type) <b>Florence Deringer Joyce</b>				Worton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Still Pond Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Still Pond, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>				ADDRESS <b>Still Pond, Ma.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 17 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Overman</b>			



6929

CERTIFICATE OF DEATH

06925

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grassville</u> 17A-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent Queen Anne Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>"Baby Girl"</u> First <u>TURNER</u> Middle Last		4. DATE OF DEATH <u>June 20</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30-1958</u>
9. AGE <u>7</u> years last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Chesapeake Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reason William Turner</u>		14. MOTHER'S MAIDEN NAME <u>Rena Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>R William Turner</u> Address <u>Grassville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> <u>760.5</u> DUE TO <u>Prothrombin Deficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature 14 30 week</u> (c) <u>Gestation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u> <u>4 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 30, 1958</u> , to <u>June 2, 1958</u> , that I last saw the deceased alive on <u>June 1, 1958</u> , and that death occurred at <u>3:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cannonsville Md</u> DATE SIGNED <u>June 2, 1958</u>			
ACTUAL SIGNATURE <u>C R Layton</u> M.D.		DATE SIGNED <u>June 2, 1958</u>	
PHYSICIAN'S NAME (Type) <u>C R Layton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 3-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Battlebeck Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural Stearnsville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Burton</u> ADDRESS <u>Burton Bros Baltimore Md</u>		24a. REC'D BY REGISTRAR <u>June 4 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Edith A. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6935

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton (Several Years)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Worton (RFD)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At home (Bigwoods)</b>		d. STREET ADDRESS <b>(Bigwoods RFD)</b>	
3. NAME OF DECEASED (Type or print) <b>Robert McKinley Whittington</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1897</b>
9. AGE (In years lost birthday) yrs. <b>61</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>Boilmaker (Bancroft Co.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kent Co. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wright Whittington</b>		14. MOTHER'S MAIDEN NAME <b>Emma Scott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW 1</b>		16. SOCIAL SECURITY NO. <b>221-03-0660</b>	
17. INFORMANT <b>Mary Whittington</b>		Address <b>Worton Md.</b> RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>58</b> , to <b>June 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 16</b> , 19 <b>58</b> , and that death occurred at <b>5:15</b> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Norbert C. Nitsch</b>		ADDRESS (Street, city or town, state) <b>Rock Hall, Md.</b> DATE SIGNED <b>June 17, 1958</b>	
PHYSICIAN'S NAME (Type) <b>Norbert C. Nitsch</b>		<b>Rock Hall, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Olivet Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>nr. Galena, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Walker</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 19 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6930

## CERTIFICATE OF DEATH

Reg. Dist. No.

06927

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Kent</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>92 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 N. Queen Street</u>			d. STREET ADDRESS <u>118 N. Queen St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hope</u> Middle <u>Wickes</u> Last <u>Wickes</u>			4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1865</u>		9. AGE (In years last birthday) <u>92 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles H. Wickes</u>			14. MOTHER'S MAIDEN NAME <u>Henrietta Whaland</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Elizabeth Westcott</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complications of old age</u> <u>794X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October</u> , 19 <u>55</u> , to <u>June 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 8</u> , 19 <u>58</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>A.C. Dick</u>		M.D. <u>Chestertown MD</u>		DATE SIGNED <u>6-27-58</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		<u>A.C. Dick</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 30, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem. near Chestertown, Md.</u>		22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Wells</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06928

6931

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN 1b <b>15 Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Kennedyville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Ann's Hospital</b>				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Willis</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 20, 1896</b>	
9. AGE (In years last birthday) yrs. <b>62</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>28</b> Hours <b>15</b> Min. <b>00</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Robert Moore</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Greenwood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Wm. Ernest Willis</b> Address <b>Kennedyville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>527.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>4 h.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemiplegia, left</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>o. n.</b> Month <b>19</b> Day <b>19</b> Year <b>1958</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Worton, Md.</b>	
20f. (City or town) <b>Worton, Md.</b>				20g. (County) <b>Worton, Md.</b>		20h. (State) <b>Worton, Md.</b>	
21. I certify that I attended the deceased from <b>June 28, 1958</b> , to <b>June 28, 1958</b> , that I last saw the deceased alive on <b>June 28, 1958</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Florence Deringer Joyce</b> M.D.				DATE SIGNED <b>6/28/58</b>			
PHYSICIAN'S NAME (Type) <b>Florence Deringer Joyce</b>				ADDRESS <b>Worton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/1/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Still Pond Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Still Pond, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>				ADDRESS <b>Still Pond, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Al Leach</b>	



6932

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kentland Greenicum Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>George Wilson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1876</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Annie Starling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>107-18-6037</u>	
17. INFORMANT <u>Records Chestertown</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension &amp; coronary artery disease</u> DUE TO (c) <u>6 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-22</u> , 19 <u>58</u> , to <u>6-3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-29</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Dick</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		DATE SIGNED <u>6-5-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Janes Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Waller</u>		24a. REC'D BY REGISTRAR <u>W. Beach</u>	
ADDRESS <u>Chestertown, Md.</u>		DATE <u>JUN 9 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1900

1. PLACE OF DEATH		2. DATE OF DEATH		3. TIME OF DEATH	
At Home		April 10, 1900		10:00 AM	
4. NAME OF DECEASED		5. SEX		6. AGE	
John Doe		Male		45	
7. OCCUPATION		8. CAUSE OF DEATH		9. PLACE OF BIRTH	
Farmer		Heart Disease		Maryland	
10. MARITAL STATUS		11. EDUCATION		12. RELIGION	
Married		High School		Roman Catholic	
13. PREVIOUS ILLNESS		14. MEDICAL ATTENDANCE		15. BURIAL PLACE	
None		Yes		Catholic Cemetery	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF PHYSICIAN	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF CLERK		21. SIGNATURE OF JUDGE	